TDAHP
Total Dental Administrators Health Plan

GROUP DENTAL ENROLLMENT FORM

☐ New Employee ☐ Decline Coverage ☐ Add/Delete Dep. ☐ Transfer from DHMO ☐ Cancel Coverage
☐ Open Enrollment ☐ Rehire ☐ Address/Name Chg ☐ Loss of Other Coverage ☐ Transfer from PPO
☐ COBRA

Name of Employer:	Group Number:
Yuma County	646150

Dental Office Selected: ☒ DHMO Provider Number #_____
(from Provider Directory or Web site)

Social Security Number:	Effective Date Mo / Day / Year	Date Employed Full Time Month / Day / Year	Hours Worked Per Week

Last Name:	First Name:	MI:	Date of Birth Month / Day / Year	Sex: Male ☐ Female ☐

Home Address:

Street:_____

Apartment # _____

City, State, Zip:_____

Home Phone:_____ **Work Phone:** _____

Do you have other Dental Coverage? If yes, Carrier:

Coverage Requested:

☐ **Employee Only**

☐ **Employee + 1 Dependent**

☐ **Family**

Complete for Dependent Coverage:

	Spouse Name-Last:	First:	MI:	Date of Birth:	Sex:
				/ /	
CHILDREN	1.			/ /	
	2.			/ /	
	3.			/ /	
	4.			/ /	
	5.			/ /	
	6.			/ /	

I hereby authorize payroll deduction, if applicable, and agree that in order to be covered by TDAHP; services must be obtained from or ordered by a TDAHP plan provider, except for emergencies. I hereby apply for enrollment and agree to remain in the plan a minimum of one year, authorize the release of any information relating to dental care received under the plan, and to all terms and conditions set forth in the Group Agreement.

Employee Signature: **Date:**

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will need to wait until Open Enrollment.

Employee Signature: **Date:**

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